FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033340

Facility Name: AVENUE CARE CENTER

Address: 4505 SOUTH DREXEL (Number) CHICAGO (City) 60653 (Zip Code)

County: COOK

Telephone Number: (847) 329-1555 **Fax #** (847) 329-9555

IDPA ID Number: 36-3558590

Date of Initial License for Current Owners: 02/01/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) SHERWIN I. RAY

(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	155	56,575	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,575	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,865	2,865	8
9	SNF/PED					9
10	ICF	48,341	433		48,774	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,341	433	2,865	51,639	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.28%

D. How many bed-hold days during this year were paid by the Department?
1,438 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/08 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 21 and days of care provided 2,807

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	179,423	20,384	11,066	210,873		210,873		210,873			1
2	Food Purchase		185,650		185,650	(17,739)	167,911	(286)	167,625			2
3	Housekeeping	143,687	36,356		180,043		180,043		180,043			3
4	Laundry	49,125	13,876		63,001		63,001		63,001			4
5	Heat and Other Utilities			159,088	159,088		159,088	54	159,142			5
6	Maintenance	43,797	18,243	41,853	103,893		103,893	7,163	111,056			6
7	Other (specify):*			12,474	12,474		12,474	41	12,515			7
8	**TOTAL General Services**	416,032	274,509	224,481	915,022	(17,739)	897,283	6,972	904,255			8
	B. Health Care and Programs											
9	Medical Director			6,500	6,500		6,500		6,500			9
10	Nursing and Medical Records	1,367,993	65,125	129,449	1,562,567		1,562,567	(92,530)	1,470,037			10
10a	Therapy	50,719	2,215	58,240	111,174		111,174	131	111,305			10a
11	Activities	90,318	9,738	10,645	110,701		110,701		110,701			11
12	Social Services	169,930			169,930		169,930		169,930			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,678,960	77,078	204,834	1,960,872		1,960,872	(92,399)	1,868,473			16
	C. General Administration											
17	Administrative	82,620		330,000	412,620		412,620	(228,216)	184,404			17
18	Directors Fees											18
19	Professional Services			284,317	284,317		284,317	(224,589)	59,728			19
20	Dues, Fees, Subscriptions & Promotions			31,763	31,763		31,763	(1,318)	30,445			20
21	Clerical & General Office Expenses	74,651	9,530	287,243	371,424		371,424	(173,695)	197,729			21
22	Employee Benefits & Payroll Taxes			365,346	365,346	17,739	383,085		383,085			22
23	Inservice Training & Education							1,404	1,404			23
24	Travel and Seminar							273	273			24
25	Other Admin. Staff Transportation			462	462		462	3,115	3,577			25
26	Insurance-Prop.Liab.Malpractice			210,088	210,088		210,088	1,581	211,669			26
27	Other (specify):*							61,156	61,156			27
28	**TOTAL General Administration**	157,271	9,530	1,509,219	1,676,020	17,739	1,693,759	(560,289)	1,133,470			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,252,263	361,117	1,938,534	4,551,914		4,551,914	(645,716)	3,906,198			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: AVENUE CARE CENTER **#0033340** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,545	
	REPAIRS & MAINTENANCE		2,521	
			0	11,066
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		87,028	
	ELECTRICITY		43,762	
	WATER		28,298	
	CABLE TV - LOBBY		0	
			0	159,088
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,792	
	PAINTING & DECORATING		1,500	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		18,937	
	ELEVATOR MAINTENANCE & REPAIR		4,817	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		5,400	
	FIRE SERVICE		7,407	
			0	
			0	
			0	41,853
7	**OTHER**			
	SCAVENGER		12,474	
	SECURITY SERVICE		0	12,474
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,500	6,500
			6,500	

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		29	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,080	
	PHARMACY CONSULTANT	XVIII B 39-2	1,440	
	UTILIZATION REVIEW FEES	XVIII B __-2	50,000	
	PHYSICIANS	XVIII B __-2	50,000	
	PSYCHIATRIC	XVIII B __-2	25,000	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL SERVICES		1,900	
			0	129,449
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		2,185	
	SPEECH THERAPY SERVICES		486	
	OCCUPATIONAL THERAPY SERVICES		1,778	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	5,400	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	5,400	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	THERAPY CONTRACT SERVICES	XVIII B 43-2	42,991	58,240
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		8,440	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,205	
			0	10,645
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number AVENUE CARE CENTER **#0033340** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	330,000	330,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	24,416	
	ADMINISTRATIVE CONSULTANTS	XIX C	218,000	
	PROFESSIONAL FEES	XIX C	41,901	
			0	284,317
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	4,133	
	EMPLOYEE WANT ADS	XIX F	21,927	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	775	
	LICENSES & PERMITS	XIX F	3,708	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	710	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	500	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	10	31,763
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		7,477	
	OUTSIDE CLERICAL SERVICES		93,056	
	PENALTIES / OVERDRAFT CHARGES	VI 18	26,885	
	HOME OFFICE EXPENSE		139,069	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		20,756	
	MESSENGER SERVICE		0	
			0	287,243

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	170,170	
	UNEMPLOYMENT COMPENSATION	XIX D	72,929	
	WORKERS COMPENSATION INSURANCI	XIX D	43,138	
	HOSPITALIZATION INSURANCE	XIX D	47,342	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,680	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	25,431	
	CHICAGO HEAD TAX	XIX D	3,656	365,346
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		462	462
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		210,088	210,088
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 1,938,534

AVENUE CARE CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	185,650	PATIENT MEALS	154917
LESS SALES TAX	(286)	ADD EMPLOYEE MEALS	16425
NET FOOD	185,364	TOTAL MEALS/YEAR	171342
TOTAL PATIENT CENSUS	51,639	NET FOOD	185364
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	171342
TOTAL PATIENT MEALS	154917	COST PER MEAL	1.08
		TIME EMPLOYEE MEALS	16425
ADD # EMPLOYEE MEALS/DAY	45		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	17739
TOTAL EMPLOYEE MEALS	16425		

Facility Name & ID Number AVENUE CARE CENTER #0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			35,274	35,274		35,274	132,765	168,039			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(150,693)	(150,693)		(150,693)	431,384	280,691			32
33	Real Estate Taxes			180,123	180,123		180,123		180,123			33
34	Rent-Facility & Grounds			494,504	494,504		494,504	(494,504)				34
35	Rent-Equipment & Vehicles			40,474	40,474		40,474	(21,314)	19,160			35
36	Other (specify):*											36
37	**TOTAL Ownership**			599,682	599,682		599,682	48,331	648,013			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		73,904	112,689	186,593		186,593	(11,425)	175,168			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			84,863	84,863		84,863		84,863			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		73,904	197,552	271,456		271,456	(11,425)	260,031			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,252,263	435,021	2,735,768	5,423,052		5,423,052	(608,810)	4,814,242			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,072	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(286)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(26,885)	21		18
19	Entertainment		20		19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(4,133)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(710)	20		28
29	Other-Attach Schedule SEE PAGE 5 A	250			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (27,192)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(581,618)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (581,618)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (608,810)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

AVENUE CARE CENTER

ID# 0033340

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 250	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	250		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number AVENUE CARE CENTER # 0033340 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(286)	0	0	0	0	0	0	0	0	0	0	(286)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	54	0	0	0	0	0	0	0	0	0	54	5
6	Maintenance	250	6,913	0	0	0	0	0	0	0	0	0	7,163	6
7	Other (specify):*	0	0	41	0	0	0	0	0	0	0	0	41	7
8	**TOTAL General Services**	(36)	6,967	41	0	0	0	0	0	0	0	0	6,972	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(125,000)	32,470	0	0	0	0	0	0	0	0	(92,530)	10
10a	Therapy	0	0	3,107	(2,976)	0	0	0	0	0	0	0	131	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(125,000)	35,577	(2,976)	0	0	0	0	0	0	0	(92,399)	16
	C. General Administration													
17	Administrative	0	(330,000)	101,784	0	0	0	0	0	0	0	0	(228,216)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(230,000)	5,411	0	0	0	0	0	0	0	0	(224,589)	19
20	Fees, Subscriptions & Promotions	(5,343)	0	4,025	0	0	0	0	0	0	0	0	(1,318)	20
21	Clerical & General Office Expenses	(26,885)	(232,069)	85,259	0	0	0	0	0	0	0	0	(173,695)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,404	0	0	0	0	0	0	0	0	1,404	23
24	Travel and Seminar	0	0	273	0	0	0	0	0	0	0	0	273	24
25	Other Admin. Staff Transportation	0	0	3,115	0	0	0	0	0	0	0	0	3,115	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,581	0	0	0	0	0	0	0	0	1,581	26
27	Other (specify):*	0	0	61,156	0	0	0	0	0	0	0	0	61,156	27
28	**TOTAL General Administration**	(32,228)	(792,069)	264,008	0	0	0	0	0	0	0	0	(560,289)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(32,264)	(910,102)	299,626	(2,976)	0	0	0	0	0	0	0	(645,716)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number AVENUE CARE CENTER # 0033340 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	5,072	0	11,105	116,588	0	0	0	0	0	0	0	132,765	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	52,177	379,207	0	0	0	0	0	0	0	431,384	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	(494,504)	0	0	0	0	0	0	0	(494,504)	34
35	Rent-Equipment & Vehicles	0	0	7,279	(28,593)	0	0	0	0	0	0	0	(21,314)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	5,072	0	70,561	(27,302)	0	0	0	0	0	0	0	48,331	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(11,425)	0	0	0	0	0	0	0	(11,425)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	(11,425)	0	0	0	0	0	0	0	(11,425)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(27,192)	(910,102)	370,187	(41,703)	0	0	0	0	0	0	0	(608,810)	45

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHAB	SKOKIE	THERAPY
				AVENUE ASSOC.		
SEE ATTACHED SCHEDULE				LLC	SKOKIE	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	HOME OFFICE EXPENSE	$ 139,069	CAREPLUS MANAGEMENT, INC.		$	$ (139,069)	1
2	V	10	MEDICARE CONSULT. FEES	50,000	" " "			(50,000)	2
3	V	10	PA CONSULTANT FEES	50,000	" " "			(50,000)	3
4	V	10	PSYCHIATRIC CONS. FEES	25,000	" " "			(25,000)	4
5	V	17	MANAGEMENT FEES	330,000	" " "			(330,000)	5
6	V	19	ADMIN. CONSULT. FEES	218,000	" " "			(218,000)	6
7	V	19	DATA PROCESS FEES	12,000	" " "			(12,000)	7
8	V	21	CLERICAL FEES	93,000	" " "			(93,000)	8
9	V								9
10	V								10
11	V	5	UTILITIES		" " "		54	54	11
12	V	6	MAINT & REPAIRS		" " "		2,573	2,573	12
13	V	6	MAINTENANCE SALARIES		" " "		4,340	4,340	13
14	Total			$ 917,069			$ 6,967	$ * (910,102)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	SECURITY	$	CAREPLUS MANAGEMENT, INC.		$ 41	$ 41	15
16	V	10	NURSING SALARIES		" " "		32,470	32,470	16
17	V	10A	THERAPY SALARIES		" " "		3,107	3,107	17
18	V	17	ADMIN. SALARIES		" " "		101,784	101,784	18
19	V	19	PROFESSIONAL FEES		" " "		5,411	5,411	19
20	V	20	ADVERTISING		" " "		4,025	4,025	20
21	V	21	TOTAL OFFICE		" " "		31,821	31,821	21
22	V	21	CLERICAL SALARIES		" " "		53,438	53,438	22
23	V	23	SEMINARS		" " "		1,404	1,404	23
24	V	24	TRAVEL		" " "		273	273	24
25	V	25	TRANSPORTATION		" " "		3,115	3,115	25
26	V	26	INSURANCE		" " "		1,581	1,581	26
27	V	27	EMPLOYEE BENEFITS		" " "		61,156	61,156	27
28	V	30	DEPRECIATION (SL)		" " "		11,105	11,105	28
29	V	32	INTEREST		" " "		52,177	52,177	29
30	V	35	EQUIPMENT RENT		" " "		7,279	7,279	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 370,187	$ * 370,187	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY SERVICES	$ 58,240	CAREPLUS REHABILITATIVE SERVICES		$ 55,264	$ (2,976)	15
16	V	39	ANCILLARY THERAPY	112,689	" " "		101,264	(11,425)	16
17	V	35	EQUIPMENT RENTAL	28,593	" " "			(28,593)	17
18	V	30	SL DEPRECIATION		" " "		5,092	5,092	18
19	V	32	INTEREST		" " "		2,835	2,835	19
20	V								20
21	V								21
22	V								22
23	V	34	RENT	494,504	AVENUE ASSOCIATES, LLC			(494,504)	23
24	V	30	SL DEPRECIATION		" " "		111,496	111,496	24
25	V	32	INTEREST		" " "		376,372	376,372	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 694,026			$ 652,323	$ * (41,703)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS								$		1
2	SHERWIN I. RAY	PRESIDENT	ADMINISTRATIC	19.70	SEE	5.6		SALARY	18,650	17-7	2
3			FINANCE		ATTACHED						3
4					SCHEDULE						4
5	ROSLYN INDICH	CLERICAL	CLERICAL	10.25		5.6		SALARY	1,534	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 20,184		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT, INC.
Street Address: 5940 W. TOUHY AVE.
City / State / Zip Code: NILES, IL 60714
Phone Number: (847) 329-1555
Fax Number: (847) 329-9555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2	5	ELECTRICITY	CENSUS DAYS	553,765	13	574		51,639	54	2
3	6	MAINT & REPAIRS	CENSUS DAYS	553,765	13	27,588		51,639	2,573	3
4	6	MAINTENANCE SALARIES	CENSUS DAYS	553,765	13	46,540	46,540	51,639	4,340	4
5	7	SECURITY	CENSUS DAYS	553,765	13	444		51,639	41	5
6	10	NURSING SALARIES	CENSUS DAYS	553,765	13	348,203	348,203	51,639	32,470	6
7	10A	THERAPY SALARIES	CENSUS DAYS	553,765	13	33,317	33,317	51,639	3,107	7
8	17	ADMIN. SALARIES	CENSUS DAYS	553,765	13	1,091,504	1,091,504	51,639	101,784	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	553,765	13	58,031		51,639	5,411	9
10	20	ADVERTISING	CENSUS DAYS	553,765	13	43,163		51,639	4,025	10
11	21	TOTAL OFFICE	CENSUS DAYS	553,765	13	341,243		51,639	31,821	11
12	21	CLERICAL SALARIES	CENSUS DAYS	553,765	13	573,059	573,059	51,639	53,438	12
13	23	SEMINARS	CENSUS DAYS	553,765	13	15,061		51,639	1,404	13
14	24	TRAVEL	CENSUS DAYS	553,765	13	2,923		51,639	273	14
15	25	TRANSPORTATION	CENSUS DAYS	553,765	13	33,401		51,639	3,115	15
16	26	INSURANCE	CENSUS DAYS	553,765	13	16,951		51,639	1,581	16
17	27	EMPLOYEE BENEFITS	CENSUS DAYS	553,765	13	655,825		51,639	61,156	17
18	30	DEPRECIATION (SL)	CENSUS DAYS	553,765	13	119,076		51,639	11,105	18
19	32	INTEREST	CENSUS DAYS	553,765	13	559,538		51,639	52,177	19
20	35	EQUIPMENT RENT	CENSUS DAYS	553,765	13	78,057		51,639	7,279	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,044,498	$ 2,092,623		$ 377,154	25

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: AVENUE ASSOCIATES LLC						$	$			$	1
2	PACIFICMUTUAL		X	MORTGAGE		12/95	4,657,452	3,935,178	01/08	0.0888	359,465	2
3	LOAN COSTS		X	LOAN COSTS	W/O OVER 12 YEARS		118,077	18,909	01/08		9,840	3
4	CIB BANK		X	CAPITAL IMPROVEMENTS		01/04	315,000	82,964	01/09	PRIME+	7,067	4
5	CAREPLUS MANAGEMENT ALLOCATION: LOC,ETC										52,177	5
	Working Capital											
6	CAREPLUS MGMT	X		WORKING CAPITAL	DEMAND		750,000			PRIME+	(154,399)	6
7	A.I. IMPERIAL CREDIT		X	INSURANCE FINANCE							3,706	7
8	CAREPLUS REHAB ALLOCATION: EQUIPMENT LOANS										2,835	8
9	TOTAL Facility Related						$ 5,840,529	$ 4,037,051			$ 280,691	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,840,529	$ 4,037,051			$ 280,691	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number AVENUE CARE CENTER **#** 0033340 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	174,149	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	176,255	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,106	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	178,017	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	180,123	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	162,147	8
2001	166,364	9
2002	168,229	10
2003	172,425	11
2004	176,255	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME AVENUE CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0033340

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	20-02-312-001-0000	NURSING HOME	$ 176,254.73	$ 176,254.73
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 176,254.73	$ 176,254.73

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,293 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	51,736	1995	$ 100,000	1
2					2
3	TOTALS	51,736		$ 100,000	3

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155		1995	1971	$ 4,046,250	$ 103,746	39	$ 103,746	$	$ 1,128,379	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SPRINKLER SYSTEM			1988	5,400	171	25	216	45	3,798	9
10	LEASEHOLD IMPROVEMENTS			1989	1,035	33	20	52	19	832	10
11	LEASEHOLD IMPROVEMENTS			1990	5,400	171	20	270	99	4,207	11
12	LEASEHOLD IMPROVEMENTS			1991	14,414	458	20	721	263	10,455	12
13	LEASEHOLD IMPROVEMENTS			1992	42,003	1,384	31.5	1,384		18,423	13
14	LEASEHOLD IMPROVEMENTS			1993	16,403	431	31.5	431		6,332	14
15	LEASEHOLD IMPROVEMENTS			1993	1,081	72	15	72		900	15
16	LEASEHOLD IMPROVEMENTS			1994	15,686	402	39	402		4,691	16
17	LEASEHOLD IMPROVEMENTS			1994	9,604		20	480	480	5,520	17
18	ELEVATOR REPAIR & DOOR			1995	44,614	1,144	39	1,144		11,774	18
19	PAVING			1995	3,600	240	15	240		2,520	19
20	ALARM SYSTEM			1996	1,820	47	39	47		456	20
21	PLUMBING			1996	2,737	70	39	70		674	21
22	WALK-IN COOLER			1996	9,998	256	39	256		2,375	22
23	DOORS AND ROOF REPAIR			1997	5,110	131	39	131		1,159	23
24	FENCE			1997	19,800	508	39	508		4,339	24
25	FLOORING/BUMPER GUARDRAILS/HANDRAILS			1997	30,579	784	39	784		6,581	25
26	BUILT-IN NURSES' STATION & WARDROBES			1997	26,176	671	39	671		5,705	26
27	SMOKE & FIRE DAMPERS			1998	7,100	182	39	182		1,311	27
28	ELEVATOR REPAIR AND LAUNDRY ROOM ELECTRICAL/CIRCU			1998	5,931	152	39	152		1,162	28
29	PARKING LOT PAVING AND LANDSCAPING			1998	53,109	3,133	15	3,541	408	26,695	29
30	FLOORING			1998	11,516	295	39	295		2,201	30
31	FIRE SAFETY UPGRADE/LIGHTING/EXHAUST/ROOF			1999	57,028	1,462	39	1,462		9,563	31
32	ONE SUMP PUMP ASSEMBLY			2000	4,200	153	27.5	153		784	32
33	RELOCATION OF A/C UNIT			2000	3,015	109	27.5	109		570	33
34	INSTALL PULL STATION & REWIRE BLDG			2000	5,878	214	27.5	214		1,097	34
35	CONCRETE STAIRS & RAMP REPLACEMENT			2001	20,000	727	27.5	727		3,302	35
36	REPLACEMENT CARPET-1ST FLOOR			2001	2,422	279	20	121	(158)	605	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LANDSCAPE INSTALLATION	2001	$ 2,910	$ 202	15	$ 194	$ (8)	$ 1,134	37
38	REPAIR PASSENGER & SMALL SERVICE ELEVATORS	2001	11,654	424	27.5	424		1,820	38
39	DECK	2001	12,170	843	15	811	(32)	4,745	39
40	SECOND FLOOR RESIDENT ROOMS-CLOSETS	2001	26,075	948	27.5	948		3,990	40
41	REPLACE PUMP MOTOR ON THE PASSENGER ELEVATOR	2002	2,580	94	27.5	94		372	41
42	BATHROOMS - INSTALLATION OF NEW SHEET VINYL	2002	1,297	47	27.5	47		143	42
43	RESIDENT BATHROOMS-NEW FLOOR	2003	3,274	119	27.5	119		342	43
44	INSTALLATION OF FIRE SPRINKLERS	2003	3,454	126	27.5	126		362	44
45	INSTALL NEW FRAMES FOR SLIDING DOORS	2003	2,765	101	27.5	101		256	45
46	BASEMENT CORRIDOR - FLOORING	2003	7,286	265	27.5	265		629	46
47	REPLACEMENT OF SEWER PIPES	2003	13,436	488	27.5	488		1,230	47
48	RECOVERY EXISTING CANOPY	2004	2,500	91	27.5	91		163	48
49	REMODELING BATHROOMS	2004	14,490	526	27.5	526		546	49
50	PAINTING HALLWAY	2005	15,280	2,292	20	764	(1,528)	764	50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59	RELATED PARTY ALLOCATION								59
60	CAREPLUS REHAB								60
61	NEW ROOF VENTILATOR	2003	909	23	39	23			61
62									62
63	CAREPLUS MGMT								63
64	BUILDING-TAG-18 PROPERTIES	2004	58,370	1,497	39	1,497			64
65	BUILDING IMPROVEMENTS-TAG-18 PROPERTIES	2004	22,931	883	39	883			65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,673,290	$ 126,394		$ 125,982	$ (412)	$ 1,282,906	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 204,662	$ 12,845	$ 19,668	$ 6,823	5-15	$ 124,202	71
72	Current Year Purchases	16,897	2,184	845	(1,339)	10	845	72
73	Fully Depreciated Assets	69,155					69,155	73
74	RELATED PARTY SL DEPRECIATION		21,544	21,544				74
75	TOTALS	$ 290,714	$ 36,573	$ 42,057	$ 5,484		$ 194,202	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	5,064,004	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	162,967	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	168,039	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	5,072	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	1,477,108	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 40,474 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19			N/A		19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 36,990	$		$ 36,990	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			792			792	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			74,907			74,907	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				65,602		65,602	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	RADIOLOGY, LABORATORY Other (specify): MEDICAL SUPPLIES	39-2 39-2					7,642 660		7,642 660	13
14	TOTAL			$		$ 112,689	$ 73,904		$ 186,593	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (167,698)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 206,391)	1,406,958		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	97,420		6
7	Other Prepaid Expenses	70,781		7
8	Accounts Receivable (owners or related parties)	2,046,253		8
9	Other(specify): Real Estate Tax Escrow	152,488		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,606,202	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	535,227		15
16	Equipment, at Historical Cost	300,318		16
17	Accumulated Depreciation (book methods)	(414,750)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	231,798		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 652,593	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,258,795	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 414,345	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	40,561		28
29	Short-Term Notes Payable	65,176		29
30	Accrued Salaries Payable	136,659		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,818		31
32	Accrued Real Estate Taxes(Sch.IX-B)	178,017		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 856,576	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 856,576	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,402,219	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,258,795	$	48

***(See instructions.)**

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,832,406	1
2	Restatements (describe):		2
3	**POST CLOSING ADJ**	(62,793)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,769,613	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	632,606	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 632,606	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,402,219	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,052,458	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,052,458	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	3,200	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,200	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,055,658	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	915,022	31
32	Health Care	1,960,872	32
33	General Administration	1,676,020	33
	B. Capital Expense		
34	Ownership	599,682	34
	C. Ancillary Expense		
35	Special Cost Centers	186,593	35
36	Provider Participation Fee	84,863	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,423,052	40
41	**Income before Income Taxes (line 30 minus line 40)****	632,606	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 632,606	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,900	2,117	$ 69,296	$ 32.73	1
2	Assistant Director of Nursing	1,385	1,418	36,823	25.97	2
3	Registered Nurses	1,563	1,566	39,315	25.11	3
4	Licensed Practical Nurses	26,465	27,253	571,451	20.97	4
5	CNAs & Orderlies	67,051	71,373	632,330	8.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,795	5,209	50,719	9.74	8
9	Activity Director	1,921	2,092	24,088	11.51	9
10	Activity Assistants	7,474	8,011	66,230	8.27	10
11	Social Service Workers	8,513	9,037	169,930	18.80	11
12	Dietician					12
13	Food Service Supervisor	2,034	2,091	31,414	15.02	13
14	Head Cook	4,517	4,701	37,449	7.97	14
15	Cook Helpers/Assistants	12,751	13,955	110,560	7.92	15
16	Dishwashers					16
17	Maintenance Workers	4,139	4,324	43,797	10.13	17
18	Housekeepers	16,675	16,892	143,687	8.51	18
19	Laundry	4,901	5,442	49,125	9.03	19
20	Administrator	1,620	1,897	48,405	25.52	20
21	Assistant Administrator	1,240	1,372	34,215	24.94	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,142	7,453	74,651	10.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,854	1,951	18,778	9.62	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	177,940	188,154	$ 2,252,263 *	$ 11.97	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 8,545	1-3	35
36	Medical Director	O	6,500	9-3	36
37	Medical Records Consultant	N	1,080	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,440	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	2,205	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) PHYSICIANS	E	50,000	10-3	46
47	UTILIZATION REVIEW FEES	S	50,000	10-3	47
48	PSYCHIATRIC		25,000	10-3	48
49	TOTAL (lines 35 - 48)		$ 155,570		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MONIQUE MOORE	ADMIN	0	$ 21,298
MARYANN WRIGHT	ADMIN	0	25,171
RAMONA RAMPERSADSINGH	ADMIN	0	1,936
MILA JEFFERY	ASST ADMIN	0	34,215
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,620

B. Administrative - Other

Description		Amount
CAREPLUS MGMT	MANAGEMENT FEES	$ 330,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 330,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		284,317
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 284,317

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 43,138
Unemployment Compensation Insurance		72,929
FICA Taxes		170,170
Employee Health Insurance		47,342
Employee Meals		17,739
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		2,680
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		25,431
CHICAGO HEAD TAX		3,656
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 383,085

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	21,927
Health Care Worker Background Check	10
(Indicate # of checks performed 1)	
MARKETING/ADV/PROMO	4,843
TRUST/FRANCHISE/CONTRIB/ETC	500
LICENSES & PERMITS	3,708
DUES & SUBSCRIPTIONS	775
MGMT CO ALLOCATION	4,025
TRUST/FRANCHISE/CONTRIB/ETC	(500)
Less: Public Relations Expense	(0)
Non-allowable advertising	(4,133)
Yellow page advertising	(710)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,445

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOCATION	273
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 273

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING	07/05	$ 1,500	YRS	$	$	$	$ 250	$ 500	$ 500	$ 250	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 1,500		$	$	$	$ 250	$ 500	$ 500	$ 250	$	$

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **48** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **84,863**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **17,739** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees